Certificate of Need Program

LETTER OF INTENT

1. Project Information *(attach additional pages as necessary to identify multiple project sites.)*

Title of Proposed Project	County

Project Address *(Street/City/State/Zip Code or plat map, if no address)*

2. Applicant Identification *(attach additional pages as necessary to list all owners and operators)*

List All Owner(s): *(list corporate entity)*	Address (Street/City/State/Zip Code)	Telephone Number

List All Operator(s): *(list entity to be licensed or certified)*	Address (Street/City/State/Zip Code)	Telephone Number

3. Type of Review

Full Review:

- ☐ New Hospital
- ☐ New/Add LTC Beds
- ☐ New/Add LTCH Beds/eqpt
- ☐ New/Additional Equipment
- ☐ Replacement Equipment not prevously approved

Expedited Review:

- ☐ 6-mile RCF Replacement
- ☐ 15-mile LTC Replacement
- ☐ 30-mile LTC Replacement
- ☐ LTC Bed Expansion
- ☐ LTC Renov./Modernization
- ☐ Equipment Replacement

Non-Applicability Review:
*(See **7. Applicability** on next page)*

4. Project Description *(information should be brief but sufficient to understand scope of project)*

Project description to include the number of long term care beds to be added, deleted or replaced, square footage of new construction and/or renovation, services affected, and major medical equipment to be acquired or replaced. If applying for a non-applicability review, also complete Page 2 of this form.

Legend: LTC = Long Term Care; LTCH = Long Term Care Hospital; RCF = Residential Care Facility

5. Estimated Project Cost: $ _____

6. Authorized Contact Person Identification *(only one per project, regardless of number of owners/operators)*

Name of Contact Person	Title

Contact Person Address *(Company/Street/City/State/Zip Code)*

Telephone Number	Fax Number	Email Address

Signature of Contact Person	Date of Signature

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7. Applicability *(check the box below to indicate the rationale for the exemption or waiver being sought)*

☐ If proposed expenditures are **less than the minimums** in §197.305(6), then attach a Proposed Expenditures form and all necessary supporting documentation to illustrate how those amounts were determined, such as schematic drawings, equipment quotes, and contractor estimates.

☐ §197.305(10)(e) for additional long term care beds in the same caegory (certified as RCF, ICF or SNF) in a RCF, nursing home, or acute care hospital costing less than $600,000, and are 10 beds or 10% of that facility's existing capacity, whichever is less.

If the proposal meets one of the **exemptions** or **exceptions** below, then check the appropriate box, explain how the proposal qualifies, and attach detailed documentation substantiating compliance with the statutory provisions as set out in Rule 19 CSR 60-50.410:

☐ §197.312 for an RCF previously owned and operated by the city of St. Louis; or

☐ §197.314(1) for a long term care facility in a tax increment financing (TIF) district with a skilled nursing facility (SNF);

☐ If the proposal meets the definition of **"nonsubstantive projects"** in §197.305(11) and 19 CSR 60-50.300(12) for a **waiver** from review, complete both pages of this form as the first step in the process, and provide the rationale as to why the proposal should be deemed to be "nonsubstantive" in the space below.

Explain the rationale for the exemption, exception, or waiver being sought: